

Immunization Record and History

PATIENT NAME (Last name, first name, middle initial)			NUMBER
BIRTHDATE	<input type="checkbox"/> Male <input type="checkbox"/> Female	KNOWN REACTIONS TO VACCINES/ALLERGIES	PRACTICE NAME/ADDRESS
VACCINES FOR CHILDREN (VFC) ELIGIBILITY (check one)			
<input type="checkbox"/> CHDP/Medi-Cal eligible <input type="checkbox"/> No health insurance <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> (Only federally qualified and rural health centers) Health insurance does not cover IZs <input type="checkbox"/> Not eligible			

If a combination vaccine (e.g., DTP + Hib or HepB + Hib) is used, record dose in each section.

VACCINE Circle one	DATE GIVEN*	MANUFACTURER AND LOT NUMBER	ADMINIS- TERED BY	SITE** VIS I.D.†	VACCINE	DATE GIVEN	MANUFACTURER AND LOT NUMBER	ADMINIS- TERED BY	SITE** VIS I.D.†
IPV/OPV 1					MMR 1				
IPV/OPV 2					MMR 2				
IPV/OPV 3					Hep B 1				
IPV/OPV 4					Hep B 2				
DTaP/DTP/ DT/Td 1					Hep B 3				
DTaP/DTP/ DT/Td 2					Varicella 1				
DTaP/DTP/ DT/Td 3					Varicella 2				
DTaP/DTP/ DT/Td 4					<input type="checkbox"/> Check here if patient had chickenpox and does not need vaccine.				
DTaP/DTP/ DT/Td 5					Hep A 1				
Td Booster					Hep A 2				
HIB 1					Pneumo Conj 1				
HIB 2					Pneumo Conj 2				
HIB 3					Pneumo Conj 3				
HIB 4					Pneumo Conj 4				
TB SKIN TESTS									
					DATE GIVEN	TYPE	DATE READ	IMPRESSION	
						<input type="checkbox"/> Mantoux <input type="checkbox"/> Other		<input type="checkbox"/> Negative <input type="checkbox"/> Positive (mm _____)	
						<input type="checkbox"/> Mantoux <input type="checkbox"/> Other		<input type="checkbox"/> Negative <input type="checkbox"/> Positive (mm _____)	
						<input type="checkbox"/> Mantoux <input type="checkbox"/> Other		<input type="checkbox"/> Negative <input type="checkbox"/> Positive (mm _____)	

Please add dates of doses given elsewhere and write in "elsewhere" or "transcribed" or name of provider.

* Date given indicates date vaccine administered and the Vaccine Information Statement (VIS) was given to the patient/parent. If VIS given at other date, write in date VIS given as well.

** Injection Site: LD=Left deltoid; LT=Left thigh; RD=Right deltoid; RT=Right thigh.

† VIS—Vaccine Information Statement, appropriate VIS must be given to parent/patient before each dose of vaccine is administered. Each VIS is identified by imprinted issue date in lower corner; record the VIS issue date here.